| | | | | | | | | I |
|-----------------------|--------------------------------|---------------------|----------------------|---|---------|---------|-----------|--------|
| IPDR6702 RUN DATE: | : 03/09/2004 | | | NORTH CAROLINA IPRS CHECKWRITE SUMMARY REPORT | | | PAGE: 1 | |
| NOW DATE: | . 55/03/2004 | | | CHECKWRITE DATE: 03/09/2004 | | | | |
| | | | | FINANCIAL PAYER: NCDMH | | | | |
| | | | | | | | | |
| PROVIDER | | | | | | | TOTAL | TOTAL |
| NUMBER | | HIGH DENIAL EOBS | NUMBER OF DENIALS | DESCRIPTION | TNC | TOTAL | CLAIMS | CLAIMS |
| | PROVIDER NAME | 2020 | DENTILLO | DEDONIT TON | DENIALS | DENIALS | FINALIZED | PAID |
| 3404901 | SMOKY MOUNTAINM | 8326 | 93 | ATTENDING PROVIDER NUMBER IS R | | | | |
| | H/DD/SAS | | | EQUIRED WHEN BILLED WITH GROUP | | | | |
| | | | | NUMBER. ADD ATTENDING NUMBER A | | | | |
| | | 21 | 28 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | 20 | DOFFICATE OF CHAIM SISTEM | 0 | 121 | 123 | 2 |
| | | | | | | | | |
| | | | | | | | | |
| 3404902 | BLUE RIDGE COMM | 8599 | 1397 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | UNITY | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 21 | 750 | DUPLICATE OF CLAIM-SYSTEM | 177 | 2851 | 4925 | 2074 |
| | | | | | | | | |
| | | | | | | | | |
| | | 101 | 100 | | | | | |
| | | 191 | 432 | CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME | | | | |
| | | | - | A SAA LERIA REPER | | | | |
| | | | _ | 1 | | | | |
| 3404904 | WESTERN HIGHLAN | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | DS LME | | | | | | | |
| | | | | | | | | |
| | | 0 | 0 | | | | | 0 |
| | | | | | 0 | 0 | 0 | 0 |
| | | | | | | | | |
| 3404905 | TREND COMM MENT | 21 | 899 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | AL HLTH CTR | | | | | | | |
| | | | | | | | | |
| | | 8599 | 403 | DETAIL NOT COVERED BY COMBINAT | 0 | 1433 | 2085 | 652 |
| | | | | ION OF RECIPIENT, PROVIDER AND | 0 | 1433 | 2085 | 652 |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 11 | 119 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | | | | DATE | | | | |
| | | | | | | | | |
| 3404907 | RUTHERFORD-POLK | 8599 | 131 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 191 | 11 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | | 191 | 11 | H PATIENT NAME | 9 | 158 | 374 | 216 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8931 | 6 | AMTNC INELIGIBLE TO RECEIVE SE | | | | |
| | | | | RVICES IN IPRS. | | | | |
| | | | - | | | | | |
| 3404910 | PATHWAYS | 8505 | 909 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | | | 1 | NT BUDGET | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8800 | 22 | FURTHER PROCESSING NECESSARY, | 0 | 944 | 1214 | 270 |
| | | - | - | PLEASE CHECK FOR CLAIM ON FUTURE RA'S. | | | | |
| | | | - | | | | | |
| | | 11 | 6 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | | | | DATE | | | | |
| | | | | | | | | |
| 3404912 | | 8505 | 1042 | CLAIM DENIED DUE TO INSUFFICIE | | | | 1 |
| | CATAWBA COUNTYM ENTAL HEALT | | | NT BUDGET | | | | |
| | ENIAL REALT | | + | | | | | 1 |
| | | | | | | | | |
| | | 8931 | 376 | AMTNC INELIGIBLE TO RECEIVE SE | 513 | 1863 | 6139 | 4276 |
| | | | | RVICES IN IPRS. | | | | |
| | | | | 0 | 1 | 1 | I . | 1 |
| | | | | | | | | |
| | | 8599 | 222 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | 8599 | 222 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |

| DD01 | | HT0H | | | | | TOTAL | TOTAL |
|----------|--------------------------------|-------------|-----------|---|---------|---------|-----------|--------|
| PROVIDER | | HIGH DENIAL | NUMBER OF | DESCRIPTION | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404913 | | 23 | 5482 | SERVICE REQUIRES PRIOR APPROVA | | | | |
| 3404913 | MECKLENBURG COM | 25 | 3402 | L | | | | |
| | ENTAL HEALT | | + | _ | | | | |
| | | | | | | | | |
| | | 8544 | 224 | CLAIM DENIED DUE TO INVALID FR | 101 | 6218 | 7264 | 1046 |
| | | | | OM DATE OF SERVICE | 101 | 0220 | 7201 | 1010 |
| | | | | | | | | |
| | | | | | | | | |
| | | 143 | 121 | CLIENT ID NUMBER NOT ON STATE | | | | |
| | | | | ELIGIBILITY FILE | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 3404916 | CROSSROADS BEHA | 21 | 65 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | VIORAL HEAL | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8621 | 31 | 60 RESIDENTIAL LEVEL III TREAT | 8 | 165 | 3528 | 3363 |
| | | | | MENT RECEIVED, PA IS REQUIRED | | | | |
| | | | | FOR ADDITIONAL SERVICE. | | | | |
| | | 0500 | 0.0 | | | | | |
| | | 8599 | 23 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | | | DENEFIT PACKAGE. | | | | |
| | | | | | | | | - |
| 3404917 | GBWBBBBB | 8599 | 246 | DETAIL NOT COVERED BY COMBINAT | | | | - |
| | CENTERPOINT HUM | | | ION OF RECIPIENT, PROVIDER AND | | | | 1 |
| | AN SERVICES | | | BENEFIT PACKAGE. | | | | |
| | | | | DENETT TROUBE. | | | | |
| | | 8505 | 207 | CLAIM DENIED DUE TO INSUFFICIE | 128 | 874 | 3415 | 2541 |
| | | | | NT BUDGET | 120 | 0,12 | 3113 | 2012 |
| | | | | | | | | |
| | | | | | | | | |
| | | 21 | 129 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 3404918 | ROCKINGHAM CO M | 8505 | 10 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | ENTAL HEALT | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 21 | 1 | DUPLICATE OF CLAIM-SYSTEM | 0 | 12 | 110 | 97 |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8599 | 1 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| 3404919 | GUILFORD CO MEN | 8505 | 7451 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | TAL HEALTHC | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 9900 | 772 | EHDMHED DDOCECCING WHOMOSON | | | | |
| | | 8800 | 773 | FURTHER PROCESSING NECESSARY, | 124 | 8690 | 10541 | 1851 |
| | | | | PLEASE CHECK FOR CLAIM ON | | | | |
| | | | + | FUTURE RA'S. | | | | - |
| | | 8599 | 132 | DETAIL NOT COVERED BY COMBINAT | | | | - |
| | | 0333 | 132 | ION OF RECIPIENT, PROVIDER AND | | | | - |
| | | | + | BENEFIT PACKAGE. | | | | - |
| | | | + | | | | | |
| 3404920 | AT AMANCE CACTOR | 8505 | 2175 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | ALAMANCE CASWEL L AREA MH D | | - | NT BUDGET | | | | |
| | T WEEN MU D | | | - | | | | |
| | | | | | | | | |
| | | 8599 | 278 | DETAIL NOT COVERED BY COMBINAT | 216 | 3242 | 4891 | 1649 |
| | | | | ION OF RECIPIENT, PROVIDER AND | 216 | 3242 | 4391 | 1049 |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 8800 | 275 | FURTHER PROCESSING NECESSARY, | | | | |
| | | | | PLEASE CHECK FOR CLAIM ON | | | | |
| | | | | FUTURE RA'S. | | | | |
| | | | | | | | | |
| | | | | | | | | |

| | | | | | | | TOTAL | TOTAL |
|----------|--------------------------------|-------------|-----------|--|---------|---------|-----------|--------|
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404921 | ORANGE PERSON C | 8505 | 2763 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | HATHAM AREA | | | NT BUDGET | | | | |
| | | 21 | 515 | DUPLICATE OF CLAIM-SYSTEM | 17 | 4249 | 5933 | 1684 |
| | | | | | | | | |
| | | 5404 | 354 | SEVERE DUPLICATE: SAME ATTO PR | | | | |
| | | | | OV/PCODE/TOS/DOS/MOD | | | | |
| | | | | | | | | |
| 3404922 | THE DURHAM CENT | 21 | 1063 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | ER | | | | | | | |
| | | 24 | | PROCEDURE CODE, PROCEDURE/MODI | | | | |
| | | 24 | 24 | FIER COMBINATION OR PROCEDURE | 0 | 1109 | 1868 | 759 |
| | | | | CODE/TYPE OF SERVICE COMBINATI | | | | |
| | | 11 | 22 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | | | | DATE | | | | |
| | | | | | | | | |
| 3404923 | VGFW AREA AUTHO | 8505 | 1339 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | RITY | | | NT BUDGET | | | | |
| | | 8800 | 72 | FURTHER PROCESSING NECESSARY, | | | | |
| | | 8800 | //2 | PLEASE CHECK FOR CLAIM ON | 3 | 1531 | 2179 | 647 |
| | | | | FUTURE RA'S. | | | | |
| | | 8599 | 52 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| 3404924 | PIEDMONT AREA M | 8525 | 12 | CLAIM DENIED, REFERRING PROVID | | | | |
| | H/DD/SAS | | | ER MUST BE AN LMA. | | | | |
| | | | | | | | | |
| | | 0 | 0 | | 0 | 12 | 12 | 0 |
| | | | | | | | | |
| 3404925 | SANDHILLS CENTE | 8505 | 6138 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | R FOR MH/DD | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 8800 | 489 | FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S. | 186 | 7505 | 10045 | 2540 |
| | | | | | | | | |
| | | 8599 | 392 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| 3404926 | | 8505 | 1593 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| 3404920 | SOUTHEASTERN RE G MENTAL HL | 0303 | 1333 | NT BUDGET | | | | |
| | | | | | | | | |
| | | 11 | 348 | CLIENT NOT ELIGIBLE ON SERVICE | 115 | 2354 | 4828 | 2474 |
| | | | | DATE | 115 | 2354 | 1020 | 24/4 |
| | | | | | | | | |
| | | 8599 | 136 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| 2404007 | | 0505 | 1000 | COLUMN DESCRIPTION OF THE PROPERTY OF THE PROP | | | | |
| 3404927 | CUMBERLAND CO M HC | 8505 | 1098 | CLAIM DENIED DUE TO INSUFFICIE NT BUDGET | | | | |
| | | | | | | | | |
| | | 8800 | 193 | FURTHER PROCESSING NECESSARY, | 6 | 1558 | 3324 | 1759 |
| | | | | PLEASE CHECK FOR CLAIM ON FUTURE RA'S. | 6 | 1558 | 3324 | 1/59 |
| | | 8599 | 71 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | ,- | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | 1 | BENEFIT PACKAGE. | L | L | 1 | |

| DDOMINED | | HIGH DENTAL | NUMBER OF | | _ | | TOTAL | TOTAL |
|--------------------|--------------------------------|---------------------|----------------------|--|---------|--|-----------|--------|
| PROVIDER NUMBER | | HIGH DENIAL EOBS | NUMBER OF DENIALS | DESCRIPTION | TNC | TOTAL | CLAIMS | CLAIMS |
| MUMBER | PROVIDER NAME | EUBS | DENTALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404929 | LEE HARNETT MH/ | 21 | 180 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | DD/SAS | | | | | | | |
| | | + | | | | | | |
| | | 8599 | 118 | DETAIL NOT COVERED BY COMBINAT | 2 | 353 | 2765 | 2412 |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 8518 | 19 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | | | | FILING TIMELIMIT. MAY AND | | | | |
| | | | | JUNE DOS MUST BE SUBMITTED BY | | | | |
| 3404930 | | 8931 | 30 | AMTNC INELIGIBLE TO RECEIVE SE | | | | |
| 3404930 | JOHNSTON COUNTY MNTL HLTHC | 0331 | 50 | RVICES IN IPRS. | | | | |
| | 11112 112110 | | | | | | | |
| | | | | | | | | |
| | | 8621 | 11 | 60 RESIDENTIAL LEVEL III TREAT MENT RECEIVED, PA IS REQUIRED | 41 | 64 | 1367 | 1303 |
| | | | | FOR ADDITIONAL SERVICE. | | | | |
| | | | | | | | | |
| | | 8935 | 7 | ASTNC INELIGIBLE TO RECEIVE SE | | | | |
| | | | | RVICES IN IPRS. | | | | |
| | | + | + | | | | | |
| 3404931 | WAKE CO HUM SVC | 8505 | 2664 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | BILLING OF | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 8800 | 145 | FURTHER PROCESSING NECESSARY, | | 2000 | 20 | |
| | | 1 | - | PLEASE CHECK FOR CLAIM ON | C | 2832 | 3031 | 199 |
| | | | | FUTURE RA'S. | | | | |
| | | | | | | | | |
| | | 21 | 13 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | + | + | | | | | |
| | | | | | | | | |
| 3404932 | RANDOLPH/SANDHI | 8599 | 92 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | LLS CO MH C | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 21 | 68 | DUPLICATE OF CLAIM-SYSTEM | 84 | 337 | 2029 | 1692 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8931 | 42 | AMTNC INELIGIBLE TO RECEIVE SE | | | | |
| | | | | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| 3404933 | | 8505 | 1896 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | SOUTHEASTERN CT R FOR MH/DD | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8800 | 151 | FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON | 47 | 2206 | 3400 | 1194 |
| | | + | | FUTURE RA'S. | | | | |
| | | | | | | | | |
| | | 8000 | 32 | NO RATE AVAILABLE ON FILE TO P | | | | |
| | | | | RICE THIS CLAIM DETAIL | | | | |
| | | + | | | | | | |
| 3404934 | ONSLOW COUNTY B | 8505 | 476 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | EHAVIORAL H | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 24 | 195 | PROCEDURE CODE, PROCEDURE/MODI | - | 1050 | 1004 | 0.50 |
| | | | | FIER COMBINATION OR PROCEDURE | 5 | 1052 | 1904 | 852 |
| | | | | CODE/TYPE OF SERVICE COMBINATI | | | | |
| | | 9900 | 105 | ENDMUED DECCESSING MEGROCORY | | | | |
| | | 8800 | 105 | FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON | | | | |
| | | + | + | FUTURE RA'S. | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 3404935 | WAYNE CO MENTAL | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | HEALTH CTR | + | + | | | | | |
| - | + | | | | | | | |
| | | | | | | | | |
| | | 0 | 0 | | C | 0 | 0 | |

| DROWIDED | | UTCU DENTAL | NUMBER OF | | | | TOTAL | TOTAL |
|--------------------|---------------------------|---------------------|----------------------|---|---------|---------|-----------|--------|
| PROVIDER NUMBER | | HIGH DENIAL EOBS | NUMBER OF DENIALS | DESCRIPTION | TNC | TOTAL | CLAIMS | CLAIMS |
| ER | PROVIDER NAME | 2000 | 22117110 | 2200111100 | DENIALS | DENIALS | FINALIZED | PAID |
| 3404936 | WILSON-GREENE M | 8505 | 73 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | ENTAL HEALT | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8931 | 69 | AMTNC INELIGIBLE TO RECEIVE SE | 108 | 240 | 1083 | 843 |
| | | | | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| | | 8932 | 25 | CMTNC INELIGIBLE TO RECEIVE SE | | | | |
| | | 0332 | 23 | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 3404937 | EDGECOMBE NASH | 21 | 2369 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | MNTL HLTH C | | | | | | | |
| | | | | | | | | |
| | | 8505 | 366 | CLAIM DENIED DUE TO INSUFFICIE | 27 | 3409 | 5721 | 2312 |
| | | | | NT BUDGET | | | | |
| | | | | | | | | |
| - | | 8599 | 277 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | 6399 | 211 | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | + | BENEFIT PACKAGE. | | | | |
| | | | + | | | | | |
| 3404938 | RIVERSTONE MENT | 8599 | 11 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | AL HEALTH C | | 1 | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 8931 | 8 | AMTNC INELIGIBLE TO RECEIVE SE | 12 | 25 | 85 | 60 |
| | | | | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| <u> </u> | | | | | | | | |
| - | | 8932 | 2 | CMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |
| | | | | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| 3404939 | NEUSE MENTAL HE | 8505 | 287 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | ALTH CENTER | | | NT BUDGET | | | | |
| | IIIII ODNIZIN | | | | | | | |
| | | | | | | | | |
| | | 11 | 217 | CLIENT NOT ELIGIBLE ON SERVICE | 29 | 961 | 2084 | 1123 |
| | | | | DATE | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8599 | 206 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | | | BENEFII FACAGE. | | | | |
| 3404941 | DTMM GO MIL/DD/G | 8599 | 136 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | PITT CO MH/DD/S AS CENTER | | 1 | ION OF RECIPIENT, PROVIDER AND | | | | |
| | AS CENTER | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 143 | 56 | CLIENT ID NUMBER NOT ON STATE | 8 | 425 | 3029 | 2604 |
| | | | | ELIGIBILITY FILE | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 120 | 51 | CLIENT ID NUMBER MISSING OR IN | | | | |
| | | | 1 | VALID. ENTER CID AND SUBMIT | | | | |
| <u> </u> | | | + | AS A NEW CLAIM | | | | |
| 3404942 | DOSMOWE CHICAGO | 11 | 75 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| 2101212 | ROANOKE CHOWANH | | 1.3 | DATE | | | | |
| | UMAN SERVIC | | + | _ | | | | |
| | | | + | | | | | |
| | | 24 | 50 | PROCEDURE CODE, PROCEDURE/MODI | 4 | 166 | 545 | 379 |
| | | | 1 | FIER COMBINATION OR PROCEDURE | * | 100 | 343 | 3/9 |
| | | | | CODE/TYPE OF SERVICE COMBINATI | | | | |
| | | | | | | | | |
| | | 8599 | 11 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| <u> </u> | | | 1 | BENEFIT PACKAGE. | | | | |
| 24040:- | 1 | 0505 | 1 | | | | | |
| 3404943 | ALBEMARLE MENTA | 8505 | 644 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | L HEALTH CE | | + | NT BUDGET | | | | |
| | | | + | | | | | |
| | | 11 | 262 | CLIENT NOT ELIGIBLE ON SERVICE | 44 | 1328 | 3649 | 2321 |
| | | | + | DATE | 44 | 1328 | 3049 | 2321 |
| | | | 1 | | | | | |
| | | 8800 | 208 | FURTHER PROCESSING NECESSARY, | | | | |
| | II. | 1 | | <u> </u> | | | | |

Sheet1

| | | PLEASE CHECK FOR CLAIM ON | | |
|--|--|---------------------------|--|--|
| | | FUTURE RA'S. | | |

| | | | | | 1 | 1 | ı | |
|--------------------|-----------------|-------------|-----------|--------------------------------|---------|---------|-----------|--------|
| | | | | | | | TOTAL | TOTAL |
| PROVIDER NUMBER | | | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404944 | | 8505 | 255 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| 3404344 | EASTPOINTE HUMA | 6303 | 233 | NT BUDGET | | | | |
| | N SERVICES | | | NI BUDGEI | | | | |
| | | | | | | | | |
| | | 8599 | 123 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | 0333 | 123 | ION OF RECIPIENT, PROVIDER AND | 135 | 706 | 4750 | 4044 |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | BEREFII FACIAGE. | | | | |
| | | 21 | 111 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | | DOI DIGHT OF COMMEN DIDIM | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| PROVIDER | | HIGH DENIAL | NUMBER OF | | | | TOTAL | TOTAL |
| NUMBER | | EOBS | DENIALS | DESCRIPTION | TNC | TOTAL | CLAIMS | CLAIMS |
| HOLDER | PROVIDER NAME | 2020 | DENTILLO | B20012111011 | DENIALS | DENIALS | FINALIZED | PAID |
| 3404946 | | 21 | 3366 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| 3101310 | FOOTHILLS AREAM | | 3300 | DOLLIGHTE OF OMITH PIDIM | | | | |
| | ENTAL HEALT | | | | 1 | | | - |
| | | | | | 1 | | | |
| | | 8000 | 724 | NO RATE AVAILABLE ON FILE TO P | 51 | 5767 | 6583 | 816 |
| | | | | RICE THIS CLAIM DETAIL | 51 | 5/6/ | 6583 | 816 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8599 | 581 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| 3404957 | TIDELAND MENTAL | 8505 | 1893 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | HEALTH CTR | | | NT BUDGET | | | | |
| | ILLABIN CIK | | | | | | | |
| | | | | | | | | |
| | | 5404 | 32 | SEVERE DUPLICATE: SAME ATTD PR | 0 | 1966 | 2006 | 40 |
| | | | | OV/PCODE/TOS/DOS/MOD | | 1300 | 2000 | 40 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8800 | 13 | FURTHER PROCESSING NECESSARY, | | | | |
| | | | | PLEASE CHECK FOR CLAIM ON | | | | |
| | | | | FUTURE RA'S. | | | | |
| | | | | | | | | |
| 3404959 | DAVIDSON CO MEN | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | TAL HLTH CT | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| | | | | | | | | |
| | | | | | | | | |
| 3404979 | NEW RIVER AREAM | 21 | 4886 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | H/DD/SA PRO | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8505 | 1972 | CLAIM DENIED DUE TO INSUFFICIE | 56 | 7531 | 8021 | 490 |
| | | | - | NT BUDGET | | | | |
| | | | | | | | | |
| | | | - | | | | | |
| | | 8800 | 423 | FURTHER PROCESSING NECESSARY, | | | | |
| | | | - | PLEASE CHECK FOR CLAIM ON | | | | |
| | | | | FUTURE RA'S. | 1 | | | 1 |